

<i>SERFF Tracking Number:</i>	<i>BFLI-126962012</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Bankers Fidelity Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>47819</i>
<i>Company Tracking Number:</i>	<i>AR B 0209 SM AP2010 DR</i>		
<i>TOI:</i>	<i>L07I Individual Life - Whole</i>	<i>Sub-TOI:</i>	<i>L07I.101 Fixed/Indeterminate Premium - Single Life</i>
<i>Product Name:</i>	<i>Application for Life Insurance</i>		
<i>Project Name/Number:</i>	<i>/</i>		

Filing at a Glance

Company: Bankers Fidelity Life Insurance Company

Product Name: Application for Life Insurance SERFF Tr Num: BFLI-126962012 State: Arkansas

TOI: L07I Individual Life - Whole SERFF Status: Closed-Approved-Closed State Tr Num: 47819

Sub-TOI: L07I.101 Fixed/Indeterminate Co Tr Num: AR B 0209 SM AP2010 State Status: Approved-Closed Premium - Single Life DR

Filing Type: Form Reviewer(s): Linda Bird
Disposition Date: 01/31/2011

Authors: Jill Jones, Bridgett Williams, Tina Cunningham, Lyn Ezell, Sharon White, Ron Crow, Norma Christopher

Date Submitted: 01/27/2011 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Authorized
Project Number:	Date Approved in Domicile: 01/05/2011
Requested Filing Mode: File & Use	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 01/31/2011
	State Status Changed: 01/31/2011
Deemer Date:	Created By: Jill Jones
Submitted By: Tina Cunningham	Corresponding Filing Tracking Number:

Filing Description:

This application is new and will not replace any previously approved form. It will be used to underwrite our previously approved direct response life products, as detailed on the forms use document attached to the Supporting Documentation tab of this filing.

SERFF Tracking Number: BFLI-126962012 State: Arkansas

Filing Company: Bankers Fidelity Life Insurance Company State Tracking Number: 47819

Company Tracking Number: AR B 0209 SM AP2010 DR

TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life

Product Name: Application for Life Insurance

Project Name/Number: /

Company and Contact

Filing Contact Information

Tina Cunningham, Compliance Analyst L1 tcunningham@atlam.com
 4370 Peachtree Road NE 404-266-5723 [Phone]
 Atlanta, GA 30319 404-926-4092 [FAX]

Filing Company Information

Bankers Fidelity Life Insurance Company CoCode: 61239 State of Domicile: Georgia
 4370 Peachtree Rd NE Group Code: 587 Company Type: Life & Health
 Atlanta, GA 30319 Group Name: 61239 State ID Number:
 (404) 266-5600 ext. [Phone] FEIN Number: 58-0658963

Filing Fees

Fee Required? No
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Bankers Fidelity Life Insurance Company	\$50.00	01/27/2011	44143632

SERFF Tracking Number:	BFLI-126962012	State:	Arkansas
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TOI:	L071 Individual Life - Whole	Sub-TOI:	L071.101 Fixed/Indeterminate Premium - Single Life
Product Name:	Application for Life Insurance		
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	01/31/2011	01/31/2011

<i>SERFF Tracking Number:</i>	<i>BFLI-126962012</i>	<i>State:</i>	<i>Arkansas</i>
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<i>Product Name:</i>	<i>Application for Life Insurance</i>		
<i>Project Name/Number:</i>	<i>/</i>		

Disposition

Disposition Date: 01/31/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: BFLI-126962012 State: Arkansas

Filing Company: Bankers Fidelity Life Insurance Company State Tracking Number: 47819

Company Tracking Number: AR B 0209 SM AP2010 DR

TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life

Product Name: Application for Life Insurance

Project Name/Number: /

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Statement of Variability		Yes
Supporting Document	Forms Use List		Yes
Form	Application for Life Insurance		Yes

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Product Name: Application for Life Insurance

Project Name/Number: /

Form Schedule

Lead Form Number: B 0209 SM AP2010 DR

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	B 0209 SM	Application/	Application for Life	Initial		47.240	B 0209 SM
	AP2010 DR	Enrollment	Insurance				AP2010 DR
		Form					john doe.pdf

BANKERS FIDELITY LIFE INSURANCE COMPANY®

4370 Peachtree Road, N.E., P. O. Box 105146, Atlanta, GA 30348-5146

APPLICATION FOR LIFE INSURANCE

PLEASE PRINT

SECTION A: Please provide the following information about yourself:

Name: (First Name, Middle Initial, Last Name) <u>John D. Doe</u>				Social Security Number <u>000-00-0001</u>
Date of Birth: (Month / Day / Year) <u>01-01-65</u>	Age <u>46</u>	Place of Birth <u>ST</u>	Sex (Check one) <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	E-mail Address <u>johndoe@email.com</u>
Address: (No. & Street, City, County, State, Zip Code) <u>#1 Main Street City, County, ST 00000-0001</u>				Daytime Phone #: (Include Area Code) <u>(404) 123-4567</u>

SECTION B: Select your benefits:

Plan of Insurance: Whole Life Requested Face Amount*: \$ <u>25,000</u> <small>*minimum \$5,000; maximum \$25,000</small> Optional Rider: <input checked="" type="checkbox"/> Accidental Death Benefit** <small>**automatically included on Whole Life Policy age 0-69</small>	Payment Method: <input type="checkbox"/> List Bill <input type="checkbox"/> Credit Card* <input checked="" type="checkbox"/> Bank Draft* <small>*Complete B 0129 MBD/CC</small>	Premium Included with Application: \$ <u>xxx.xx</u> <input type="checkbox"/> Check here if initial premium is to be paid by credit card. <input type="checkbox"/> Check/money order included. <input type="checkbox"/> Draft initial premium* *Initial draft date <u>02-01-11</u>
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SECTION C: Please answer the following health and medical questions about yourself:

- In the last 5 years, have you had or been medically diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or tested positive for the Human Immunodeficiency Virus (HIV)? ☐ Yes ☒ No
- In the last 3 years, have you had or been medically diagnosed with or treated for:
 - cirrhosis, liver disease, hepatitis (excluding Type A), kidney/renal failure or insufficiency, chronic kidney disease, or been advised to have or had dialysis? ☐ Yes ☒ No
 - Alzheimer's disease, dementia or organic brain syndrome? ☐ Yes ☒ No
 - muscular dystrophy, Lou Gehrig's disease (ALS) or sickle cell anemia? ☐ Yes ☒ No
- In the past year, have you:
 - been confined to a hospital 3 or more times or to a nursing facility or receiving home health care or assistance with normal activities of daily living, such as dressing, bathing, eating, transferring, or toileting? ☐ Yes ☒ No
 - been confined to a wheelchair or require the use of a wheelchair or motorized mobility aid due to a medical condition or on the advice of a physician? ☐ Yes ☒ No
 - been medically advised to have surgery or treatment or hospital/nursing facility confinement and not done so? ☐ Yes ☒ No
 - had any heart or circulatory surgery? ☐ Yes ☒ No
- In the last 3 years, have you had, been medically diagnosed with, or treated for:
 - heart attack, stroke, congestive heart failure, or amputation due to disease? ☐ Yes ☒ No
 - emphysema, chronic obstructive pulmonary disease (COPD), chronic bronchitis, or used supplemental oxygen? .. ☐ Yes ☒ No
 - internal cancer, leukemia, malignant melanoma, or Hodgkin's disease? ☐ Yes ☒ No
 - Schizophrenia or delusional or psychotic disorder, alcoholism or drug addiction? ☐ Yes ☒ No
 - Parkinson's or Huntington's disease, multiple sclerosis, or systemic lupus? ☐ Yes ☒ No
 - complications of diabetes, diabetic coma, or insulin shock? ☐ Yes ☒ No
 - testing or surgery for the transplanting of any organ or tissue (excluding corneal transplants)? ☐ Yes ☒ No

5. Please provide complete name, address and telephone number of your primary care physician:

Physician's name: Dr. Bob Physician Telephone number (404) 234-5678
 Physician's address: #1 Medical Ctr, City, ST 00000-0001

6. Are you a legal citizen of the United States or its possessions? ☒ Yes ☐ No
 If "No," are you a Permanent Resident? ☐ Yes ☐ No If "No," coverage is not available.
 If "Yes," provide the following information as shown on your Permanent Resident Card:

I.N.S. # _____ CATEGORY _____ RESIDENT SINCE _____ CARD EXPIRES _____

(Application continued)

7. (a) Do you currently have any life insurance policies or annuity contracts in force or pending? ☐ Yes ☒ No
 If "Yes": Name of company(ies) _____ Face Amount \$ _____ Policy No. _____
attach additional sheets if necessary (if known)
- (b) Will any life insurance or annuity contract be replaced with this policy of whole life insurance? ☐ Yes ☒ No

8. (a) Name of Primary Beneficiary(ies)	Relationship	Social Security No. (If known)	Address	Telephone No.
Jane D. Doe	wife	000-00-0002	same	same
(b) Name of Contingent Beneficiary(ies)	Relationship	Social Security No. (If known)	Address	Telephone No.
John D. Doe Jr.	Son	000-00-0003	same	same
(c) Name of Payor (if other than insured)	Relationship	Social Security No. (If known)	Address	Telephone No.
(d) Name of Owner (if other than insured)	Relationship	Social Security No. (If known)	Address	Telephone No.

SECTION D: Please read the following agreement and sign at the bottom:

9. I, the undersigned, hereby apply to Bankers Fidelity Life Insurance Company for a policy to be issued solely and entirely in reliance on my written answers to the above questions. I represent that the answers given are, to the best of my knowledge and belief, true. I agree the policy shall not be effective unless it has actually been issued, received by me and the first premium paid, all during my lifetime and before any change in my health as stated herein.

I realize that any false statement or misrepresentation in the application may result in loss of coverage under the policy, subject to the "Incontestability" provision of the policy.

CAUTION: If the answers on this application are incorrect or untrue, Bankers Fidelity Life Insurance Company has the right to deny benefits or rescind your policy, subject to the "Incontestability" provision of the Policy.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be committing a fraudulent insurance act, which is a crime and could subject such person to criminal and civil penalties.

Dated at CITY, ST, on 01-01-11 X John D. Doe
(City and State) (Month, Day, Year) Proposed Insured's Signature. Please read item #9 before signing.
 X John Doe Agent 0000
Owner's Signature (if other than Proposed Insured)

B 0209 SMAP2010 DR

(1-11)

AUTHORIZATION TO HONOR RECURRING DRAFTS/WITHDRAWALS/CHARGES MADE BY AND PAYABLE TO BANKERS FIDELITY LIFE INSURANCE COMPANY®, ATLANTA, GA

I hereby authorize you to pay from and charge to my account listed below any draft, withdrawal or charge, including electronic transactions, made by and payable to Bankers Fidelity Life Insurance Company, Atlanta, GA for the premiums due on my insurance policy, provided there are sufficient funds in said account to honor such draft, withdrawal or charge upon presentation. I agree that your rights in respect to each draft, withdrawal or charge shall be the same as if it were a check, withdrawal or charge made personally by me.

This authorization shall remain in effect until Bankers Fidelity Life Insurance Company has received written notification from me revoking this authorization and in such manner as to afford reasonable opportunity to act upon it. I agree that if any draft, withdrawal or charge is dishonored or refused, you shall be under no liability whatsoever, even if such dishonor or refusal results in the forfeiture of insurance.

SELECT A OR B

A. ☐ CHECKING AUTHORIZATION ☐ SAVINGS ACCOUNT AUTHORIZATION

Name of Financial Institution:		Type of Financial Institution: <input type="checkbox"/> Bank <input type="checkbox"/> Credit Union	
Routing/ABA Number:	Account Number:		Attach a voided check if the account number is different than the account number on the initial premium. If the authorization is for a Savings Account, attach a deposit slip.
Signature of Account Holder		Date	

B. ☐ CREDIT CARD AUTHORIZATION

Type of Card: <input type="checkbox"/> Mastercard <input type="checkbox"/> Visa <input type="checkbox"/> Discover	Account Number:	Expiration Date _____ / _____ Month Year
Name of Card Holder as it appears on account		Date
Signature of Card Holder		

B 0129 MBD/CC

(8-03)

SERFF Tracking Number: BFLI-126962012 State: Arkansas
Filing Company: Bankers Fidelity Life Insurance Company State Tracking Number: 47819
Company Tracking Number: AR B 0209 SM AP2010 DR
TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
Product Name: Application for Life Insurance
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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: B 0209 SM AP2010 DR Flesch Cert.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application Comments: Attachment: B 0209 SM AP2010 DR john doe.pdf		

	Item Status:	Status Date:
Satisfied - Item: Statement of Variability Comments: Attachment: B 0209 SM AP2010 DR Statement of Variability.pdf		

	Item Status:	Status Date:
Satisfied - Item: Forms Use List Comments: Attachment: AR B 0209 SM AP2010 DR Forms Use List.pdf		

BANKERS FIDELITY LIFE INSURANCE COMPANY

4370 Peachtree Road, N.E., Atlanta, Georgia 30319
(404) 266-5657

FLESCH SCORE CERTIFICATION

B 0209 SM AP2010 DR – Application

Words:	369
Sentences:	12
Syllables:	560
Score:	47.24

I hereby certify that the Flesch reading ease score of the above forms is as shown.



Sharon A. White
Vice President; Legal/Compliance



Date

BANKERS FIDELITY LIFE INSURANCE COMPANY®

4370 Peachtree Road, N.E., P. O. Box 105146, Atlanta, GA 30348-5146

APPLICATION FOR LIFE INSURANCE

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Date of Birth: (Month / Day / Year) <u>01-01-65</u>	Age <u>46</u>	Place of Birth <u>ST</u>	Sex (Check one) <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	E-mail Address <u>johndoe@email.com</u>
Address: (No. & Street, City, County, State, Zip Code) <u>#1 Main Street City, County, ST 00000-0001</u>				Daytime Phone #: (Include Area Code) <u>(404) 123-4567</u>

SECTION B: Select your benefits:

Plan of Insurance: Whole Life Requested Face Amount*: \$ <u>25,000</u> <small>*minimum \$5,000; maximum \$25,000</small> Optional Rider: <input checked="" type="checkbox"/> Accidental Death Benefit** <small>**automatically included on Whole Life Policy age 0-69</small>	Payment Method: <input type="checkbox"/> List Bill <input type="checkbox"/> Credit Card* <input checked="" type="checkbox"/> Bank Draft* <small>*Complete B 0129 MBD/CC</small>	Premium Included with Application: \$ <u>xxx.xx</u> <input type="checkbox"/> Check here if initial premium is to be paid by credit card. <input type="checkbox"/> Check/money order included. <input type="checkbox"/> Draft initial premium* *Initial draft date <u>02-01-11</u>
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 - Alzheimer's disease, dementia or organic brain syndrome? ☐ Yes ☒ No
 - muscular dystrophy, Lou Gehrig's disease (ALS) or sickle cell anemia? ☐ Yes ☒ No
- In the past year, have you:
 - been confined to a hospital 3 or more times or to a nursing facility or receiving home health care or assistance with normal activities of daily living, such as dressing, bathing, eating, transferring, or toileting? ☐ Yes ☒ No
 - been confined to a wheelchair or require the use of a wheelchair or motorized mobility aid due to a medical condition or on the advice of a physician? ☐ Yes ☒ No
 - been medically advised to have surgery or treatment or hospital/nursing facility confinement and not done so? ☐ Yes ☒ No
 - had any heart or circulatory surgery? ☐ Yes ☒ No
- In the last 3 years, have you had, been medically diagnosed with, or treated for:
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 - emphysema, chronic obstructive pulmonary disease (COPD), chronic bronchitis, or used supplemental oxygen? .. ☐ Yes ☒ No
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 - Parkinson's or Huntington's disease, multiple sclerosis, or systemic lupus? ☐ Yes ☒ No
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 - testing or surgery for the transplanting of any organ or tissue (excluding corneal transplants)? ☐ Yes ☒ No

5. Please provide complete name, address and telephone number of your primary care physician:

Physician's name: Dr. Bob Physician Telephone number (404) 234-5678
 Physician's address: #1 Medical Ctr, City, ST 00000-0001

6. Are you a legal citizen of the United States or its possessions? ☒ Yes ☐ No
 If "No," are you a Permanent Resident? ☐ Yes ☐ No If "No," coverage is not available.
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(Application continued)

7. (a) Do you currently have any life insurance policies or annuity contracts in force or pending? ☐ Yes ☒ No
 If "Yes": Name of company(ies) _____ Face Amount \$ _____ Policy No. _____
attach additional sheets if necessary (if known)
- (b) Will any life insurance or annuity contract be replaced with this policy of whole life insurance? ☐ Yes ☒ No

8. (a) Name of Primary Beneficiary(ies)	Relationship	Social Security No. (If known)	Address	Telephone No.
Jane D. Doe	wife	000-00-0002	same	same
(b) Name of Contingent Beneficiary(ies)	Relationship	Social Security No. (If known)	Address	Telephone No.
John D. Doe Jr.	Son	000-00-0003	same	same
(c) Name of Payor (if other than insured)	Relationship	Social Security No. (If known)	Address	Telephone No.
(d) Name of Owner (if other than insured)	Relationship	Social Security No. (If known)	Address	Telephone No.

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Dated at CITY, ST, on 01-01-11 X John D. Doe
(City and State) (Month, Day, Year)
 X John Doe Agent 0000
Proposed Insured's Signature. Please read item #9 before signing.
Owner's Signature (if other than Proposed Insured)

B 0209 SMAP2010 DR

(1-11)

AUTHORIZATION TO HONOR RECURRING DRAFTS/WITHDRAWALS/CHARGES MADE BY AND PAYABLE TO BANKERS FIDELITY LIFE INSURANCE COMPANY®, ATLANTA, GA

I hereby authorize you to pay from and charge to my account listed below any draft, withdrawal or charge, including electronic transactions, made by and payable to Bankers Fidelity Life Insurance Company, Atlanta, GA for the premiums due on my insurance policy, provided there are sufficient funds in said account to honor such draft, withdrawal or charge upon presentation. I agree that your rights in respect to each draft, withdrawal or charge shall be the same as if it were a check, withdrawal or charge made personally by me.

This authorization shall remain in effect until Bankers Fidelity Life Insurance Company has received written notification from me revoking this authorization and in such manner as to afford reasonable opportunity to act upon it. I agree that if any draft, withdrawal or charge is dishonored or refused, you shall be under no liability whatsoever, even if such dishonor or refusal results in the forfeiture of insurance.

SELECT A OR B

A. ☐ CHECKING AUTHORIZATION ☐ SAVINGS ACCOUNT AUTHORIZATION

Name of Financial Institution:		Type of Financial Institution: <input type="checkbox"/> Bank <input type="checkbox"/> Credit Union	
Routing/ABA Number:	Account Number:		Attach a voided check if the account number is different than the account number on the initial premium. If the authorization is for a Savings Account, attach a deposit slip.
Signature of Account Holder	Date		

B. ☐ CREDIT CARD AUTHORIZATION

Type of Card: <input type="checkbox"/> Mastercard <input type="checkbox"/> Visa <input type="checkbox"/> Discover	Account Number:	Expiration Date _____ / _____ Month Year
Name of Card Holder as it appears on account		Date
Signature of Card Holder		

B 0129 MBD/CC

(8-03)

STATEMENT OF VARIABILITY

Application for Life Insurance

Form: **B 0209 SM AP2010 DR**

ITEM

VARIABILITY

Checkboxes for Life Insurance Plans

ability to remove plans that are no longer offered or offer additional that are later approved by the state; the options are shown on the Forms Use document attached to the filing

Checkboxes for Optional Rider(s)

ability to remove riders that are no longer offered or offer additional that are later approved by the state; the options are shown on the Forms Use document attached to the filing

**Application for Life Insurance: B 0209 SM AP2010 DR
FORMS TO BE USED WITH**

Arkansas

The Application for Life Insurance may be issued with the following policy forms and riders:

<u>Form Number</u>	<u>Description / Title</u>	<u>Approved by State</u>
B 20604 DR	Endowment at Age 100	07-10-2006
B 20801 DR	Level Whole Life Insurance	10-06-2008
B 20802 DR	Modified Whole Life Insurance	12-02-2008
B 0109 TI ADB 50 (R09)	Accelerated Death Benefit Rider	11-09-2010
B 0108 WP NHC	Waiver of Premium Rider	07-01-1997
B 0210 ADB	Accidental Death Benefit Rider	01-05-2011
BFL-CIR	Children's Insurance Rider	01-18-1988
BFL-WPD	Waiver of Premium for Disability Rider	01-18-1989